STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/24/2015

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ROSEWALK AT LUTHERWOODS	1301 N RITTER AVE INDIANAPOLIS, IN 46219

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R 000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey Dates: February 23 and 24, 2015 Facility Number: 011587 Provider Number: 011587 AIM Number: N/A Survey Team: Karina Gates, Generalist, TC Beth Walsh, RN Angie Stallsworth, RN Tom Stauss, RN (February 23, 2015 only) Census Bed Type: Residential: 76 Total: 76 Census Payor Type: Other: 76 Total: 76 Sample: 9 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 25, 2015 by Cheryl Fielden, RN.	R 000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Survey Review on or after 03/12/15.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R 091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to implement their policies regarding administration of PRN (as needed) medications and obtaining a chest x-ray upon resident admission for 2 of 9 residents reviewed for policy implementation. The facility also failed to establish a policy in regards to following physician's orders for 1 of 9 residents reviewed for facility policy establishment. (Resident #31, #41, and #76) Findings include: 1. The clinical record for Resident #31 was reviewed on 2/23/15, at 2:00 p.m. The diagnoses for Resident #31 included, but were not limited to, anxiety. The February, 2015 Physician's Orders for Resident #31 indicated a 0.5 mg tablet	R 091	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?Licensed nurses and Qualified Medication Aides were re-educated by 03/09/15 on facility policy for the administration of PRN (as needed) medications, including but not limited to, the QMA must receive appropriate authorization for each administration of a PRN medication and shall document nurse authorization on the back of the MAR. Licensed nurses and admissions staff were re-educated by 03/09/15 on facility policy for History and Physical, including but not limited to, Resident must have chest x-ray not more than 6 months prior to admission to facility. Resident #41 received chest x-ray on 02/24/15. A facility policy titled Physicians Orders was implemented and licensed nurses educated by 03/09/15, including	03/12/2015

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	of Lorazepam (anti-anxiety medication) to be given 3 times daily as needed for anxiety, effective 1/14/15. The pharmacy tracking log for the above mentioned anti-anxiety medication indicated Resident #31 received the medication on the following dates and times by QMA (Qualified Medication Aide) #3: 1/14/15 at 10:00 p.m. 1/30/15 at 9:00 p.m. 2/9/15 at 8:00 p.m. 2/13/15 at 4:00 p.m. 2/13/15 at 8:00 p.m. The January and February, 2015 MARs (medication administration records) did not indicate QMA #3 documented nurse authorization on the backs of the MARs for the above administrations. An interview was conducted with the DHS (Director of Health Services) on 2/24/15, at 9:35 a.m. After reviewing the January and February, 2015 MARs for Resident #31, the DHS indicated she wouldn't doubt QMA #3 asked permission to administer the PRN Lorazepam, but forgot to document on the backs of the MARs. She indicated both the nurse and QMA #3 should have documented, but especially QMA #3,		but not limited to, review of physician orders for accuracy, order omissions, obtaining any necessary order clarifications, and transcription onto current MAR. Licensed nurses were educated on 03/02/15 by pharmacist on insulin order accuracy. Resident #76 orders were reviewed by Clinical Director and MD. How will other Residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?All Residents have the potential to be affected. Clinical Director/designee performed audit of all resident Medication Administration Records (MARs) and Physicians Orders by 03/02/15, including but not limited to PRN medication authorizations by licensed nurse and physician order accuracy and transcription to MAR. Staff were educated by 03/09/15 on PRN Medications, Admission History and Physical, and Physicians Orders policies by Clinical Director.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?Staff were educated by 03/09/15 on PRN Medications, Admission History and Physical, and Physicians Orders policies by Clinical Director. Clinical Director/designee will be responsible for auditing daily physicians orders and PRN	

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	since she administered the PRN lorazepam to Resident #31. The PRN Medications policy was provided by the DHS on 2/24/15, at 10:05 a.m. It indicated, "If QMA is administering the PRN medications: The QMA must receive appropriate authorization for each administration of a PRN medication....QMA shall document nurse authorization on back of the MAR."2. The clinical record for Resident #41 was reviewed on 2/23/15 at 2:44 p.m. The diagnoses for Resident #41 included, but were not limited to, diabetes mellitus, urinary retention, osteoarthritis, and hypertension. Resident #41 was admitted on 11/5/14. A chest x-ray for Resident #41 was not located in the clinical record. During an interview with the Clinical Director, on 2/24/15 at 2:31 p.m., she indicated the facility was unable to locate a chest x-ray for Resident #41, but the facility was able to locate a CT scan done at a hospital within 6 months of Resident #41's admission to the facility. A policy titled, History and Physical, dated 11/08, was received from the Clinical Director on 2/24/15 at 2:45 p.m. The policy indicated, "...The prospective		Medication authorizations to ensure policies are followed. Clinical Director/designee will be responsible for auditing new admissions for chest-xray per facility policy at date of admission. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A CQI tool will be completed as a monitoring tool. This tool will be completed weekly x 4, bi-monthly x 2, then on quarterly basis until continued compliance is maintained for 2 consecutive quarters by the Clinical Director or designee. If a threshold of 95% is not met, the results will be reviewed at monthly At-Risk meetings and an action plan will be developed and/or disciplinary action. The CQI tool will be overseen by the Clinical Director and General Manager.	

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	resident visits his or her physician to be examined and to have the History & Physical completed...." A form titled, History and Physical/Physician Statement Form, which was part of the History and Physical policy indicated the following statement on the form, "...Please fill in below or provide a copy of a 2 Step TB test not more than 30 days old and a chest x-ray not more than six months old. Every resident must have this prior to moving into our Community...."3. The clinical record for Resident #76 was reviewed on 2/23/15, at 1:00 p.m. The current diagnoses included, but were not limited to, diabetes mellitus type II and left below the knee amputation. A physician order dated 1/6/15, indicated blood sugars to be taken three times a day before meals, and to administer 4 Units of Novolog (insulin) with each meal. A resident care note dated 1/6/15 indicated the nurse practitioner ordered blood sugars to be checked three times a day with meals, and to administer 40 units of Novolog with each meal. The Medication Administration Record dated on 1/6/15 through 1/31/15 indicated an order of Novolog 40 units SQ (subcutaneous) with each meal.			

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	Resident #76's 1/7/15 "Diabetic Monitoring Flowsheet" indicated an 11:00 a.m., blood sugar reading of 39. It indicated Resident #76 was provided orange juice and glucose, the blood sugar was rechecked, and the reading was 79. Resident #76 was provided lunch at that time. A resident care note dated on 1/7/15 indicated "clarification: Novolog 4 units SQ (subcutaneous) (TID) three times a day with meals. Resident given 40 units this am with breakfast D/T (due to) order on MAR (medication administration record). BS (blood sugar) @ 11a (a.m.) 31, OJ (orange juice), glucose, and crackers given. Recheck BS (blood sugar) 79, res (resident) down to lunch. MD aware." The 1/7/15 physician order indicated clarification: Novolog 4 units SQ (subcutaneous) TID (three times a day) with meals. A form titled, "72 Hour Follow Up Charting" for Resident #76 was indicated on 1/8/15 for wrong dose of insulin. Resident was monitored for three days for adverse reactions. An interview was conducted on 2/23/15, at 2:30 p.m., with the Clinical Director			

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	and LPN #4. LPN #4 indicated therapy notified her on the morning of 1/7/15 in regards to Resident #76 being a "little shaky". LPN #4 indicated, at that time, the 11:00 a.m. blood sugar was due, so she checked it, and the reading was 39. The Clinical Director indicated on the physician's order the "U" in units was written close to the number 4, and was interpreted by staff as a zero, instead of a letter "u". The Clinical Director indicated the physician was notified at that time regarding the low blood sugar, and clarified Resident #76 was to receive 4 units of Novolog, not 40 units. An interview with the Clinical Director on 2/24/15 at 12:15 p.m. indicated the facility does not have a policy regarding following physician orders.			
R 121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid			

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	personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on interview and record review, the facility failed to ensure a current employee had any documented tuberculin (TB) skin testing done prior to working for 1 of 5 employee personnel files reviewed. (CNA #5) Findings include: The Employee Records form and TB skin testing were reviewed on 2/24/15 at 10:15 a.m. CNA #5 had a start date of	R 121	What corrective action(s) will be accomplished for those Resident affected by the deficient practice? CNA#5 received Mantoux (PPD) TB skin testing, and record placed in employee's personnel file. How will other Residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?All employee files audited for tuberculin (TB) skin testing to identify any employees without TB skin testing by 03/09/15.	03/12/2015

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	10/23/14. Upon review of TB skin testing, no TB skin testing was found for CNA #5. During an interview with the General Manager, on 2/24/15 at 3:08 p.m., she indicated the facility was unable to locate any TB skin testing for CNA #5. A policy titled, Employee Screening-Tuberculosis (TB), dated 12/11, was received from the General Manager after final exit from the facility, on 2/25/15 at 9:05 a.m. The policy indicated, "...C. Status [-] Initial Hire [,] Type [-] Two-Step...Procedure[-] Administer post offer, if employee has not a documented negative Mantoux (PPD) during preceding 12 months....F. Documentation....3. The Tuberculin Testing for Employee Form should be kept in the employees [sic] personnel file...."		Department managers will be re-educated by 03/09/15 on Employee Screening-TB policy by General Manager. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Department managers will be re-educated by 03/09/15 on Employee Screening-TB policy by General Manager. Business Office Manager/designee will be responsible for auditing employee personnel files on date of hire for completion of first-step Mantoux (PPD) and monthly for completion of second-step PPD, as applicable per facility employee screening-TB policy. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An Employee Personnel File CQI tool will be completed as a monitoring tool. This tool will be completed weekly x 4, bi-monthly x 2, then on quarterly basis until continued compliance is maintained for 2 consecutive quarters by the Business Office Manager/designee. If a threshold of 100% is not met, the results will be reviewed at monthly At-Risk meetings and an action plan will be developed and/or disciplinary action. The CQI tool will be overseen by the Business Office Manager and General Manager.	

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